DD-023-PF (5-07)
P/P Ch. 500

Clear The Form

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

APPLICATION FOR ELIGIBILITY DETERMINATION

☐ New Eligibility ☐ Redetermination of Eligibility

APPLICANT'S INFORMATION

APPLICANT'S NAME *(Last, First, M.I.)* | PHONE NO.

BIRTHDATE | BIRTHPLACE

PHYSICAL ADDRESS *(No., Street, City, State, ZIP)*

MAILING ADDRESS, IF DIFFERENT FROM ABOVE *(No., Street/P.O. Box, City, State, ZIP)* | COUNTY

ARE YOU A U.S. CITIZEN OR A PERMANENT RESIDENT ALIEN
☐ Yes ☐ No

HAVE YOU EVER APPLIED FOR DDD SERVICES IN THE PAST *(If yes, please specify)*
☐ Yes ☐ No When: Where:

RESPONSIBLE PERSON'S INFORMATION

I am applying as or for the person named above who is a resident of the State of Arizona. I have been informed of the services provided by this agency. I understand that if I am referred to AHCCCS for an ALTCS eligibility determination, I must cooperate in this determination process. As part of my application to this Division, I have been informed of the DDD eligibility criteria and of my rights relevant to the application process. If I am eligible and assigned to services, I authorize the release of information necessary to file a claim to my insurance company and I authorize payment of benefits to DDD or its contracted provider(s).

RESPONSIBLE PERSON'S NAME *(Please print)* | RELATIONSHIP TO APPLICANT *(e.g., parent, court appointed guardian, etc.)*

RESPONSIBLE PERSON'S SIGNATURE | DATE

DOCUMENTED DISABILITIES *(To be completed by DDD representative, if eligible)*

☐ At Risk ☐ Autism ☐ Cerebral Palsy ☐ Epilepsy ☐ Cognitive Disability

LEVEL OF MENTAL RETARDATION *(If applicable)*:
☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Undetermined

FUNCTIONAL LIMITATIONS *(For applicants 6 years of age and over)*:
☐ Self-Care ☐ Receptive and Expressive Language ☐ Learning ☐ Mobility
☐ Capacity for Independent Living ☐ Self-Direction ☐ Economic Self-Sufficiency

ELIGIBLE FOR ARIZONA EARLY INTERVENTION PROGRAM (AzEIP):
☐ Yes ☐ No ☐ N/A

ELIGIBILITY DETERMINATION

☐ We are pleased to notify you that _____ has been determined eligible.
Applicant's Name

To discuss service request and availability, please contact _____ at _____
Name of DDD Representative *Phone No.*

☐ We are sorry to inform you that _____ has been determined ineligible.
Applicant's Name

Please see attached letter.

SIGNATURE OF DDD REPRESENTATIVE DETERMINING ELIGIBILITY | DATE

Equal Opportunity Employer/Program ♦ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at (602) 542-6825; TTY/TDD Services: 7-1-1.